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| RESEARCH ARTICLE

Compulsive Buying-Shopping Disorder Associated with Recurrent Depressive Disorder: A Case Report

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| ABSTRACT

Compulsive buying – shopping disorder remains an incompletely defined and controversial pathology to our days. However, in the last years, progress has been made in establishing diagnostic criteria and developing new assessment instruments. In the absence of inclusion in the main diagnostic systems and without a largely accepted diagnostic criteria, compulsive buying shopping disorder is rarely recognized and diagnosed in clinical practice. In this context, we present the case of a 61-year-old female with compulsive buying–shopping disorder associated with recurrent depressive disorder. Our patient's symptoms met almost completely the set of criteria proposed by Müller et al. Even though the diagnosis of this disorder in our patient was not followed by a successful pharmacological intervention, we believe it brought a better understanding of the case, which may lead to a more successful approach in the future.

| KEYWORDS

Compulsive buying disorder, Compulsive shopping disorder, Compulsive buying-shopping disorder, Recurrent depressive disorder

| ARTICLE INFORMATION

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1. Introduction

As described since the beginning of the 20th century by both Bleuler (Bleuler, 1934) and Krepelin (Kraepelin, 1915), excessive buying was then seen as an impulse disorder or as a compulsion (Bleuler, 1934) (Kraepelin, 1915). Despite the long period of time since first described, the attention received by this maladaptive behavior was much less than that received by other psychiatric and behavioral disorders. Still, in the last years, an increasing number of researchers have been discussing different aspects of excessive buying. Thus, at the present time, there is a wide range of names and descriptions that try to define maladaptive, excessive buying. Some of the most frequently encountered names in the literature are compulsive shopping disorder, compulsive buying disorder (Black, 2007) (Mueller et al., 2010), compulsive buying behavior (Ye, 2021), compulsive shopping (Black, 2022), shopping addiction (Lejoyeux & Weinstein, 2013), and problematic shopping behavior (Ünübol et al., 2022). As observed from the names given to the presumed disorder, it is mostly seen as a compulsion or as an impulse control problem (Ye and He, 2021) (Black, 2022) or as an addiction (Lejoyeux & Weinstein, 2013) (Ünübol et al., 2022).

Over time several instruments have been designed to screen for compulsive buying shopping disorders. Some of them are Compulsive Buying Scale (Faber and O'Guinn, 1992), Richmond Compulsive Buying Scale (Ridgway et al., 2008) and Pathological Buying Screener (Müller et al., 2015).

In 1994, McElroy et al. suggested a set of 3 diagnostic criteria (McElroy et al., 1994). The first criterion describes a buying behavior characterized either as an intrusive concern or irresistible urge to buy or as being excessive in relation to either of the following three circumstances: financial status (e.g. more than the person can afford), one's necessity (buying unnecessary items) or duration of time spent buying things. The second criterion is related to the consequences of the aforementioned behavior and refers to distress as a consequence of either intrusive concern or repetitive behavior and to interference with social, occupational, and financial domains. The third criterion excludes the situation in which manic or hypomanic episodes are the only times when excessive buying happens (McElroy et al., 1994).

Later on, in 2021, Müller A. et al. proposed a set of criteria for compulsive buying-shopping disorder (CBSD) as a result of a Delphi consensus study including 138 experts from 35 countries (Müller et al., 2021). Laskowski et al. carried out research comparing clinicians' and researchers' opinions regarding the set of criteria proposed by Müller et al. and found no differences between the two groups (Laskowski et al., 2023).

In our paper, we aim to present the case of a patient with recurrent depressive disorder associated with CBSD. In addition to presenting the symptoms displayed by our patient, we assessed the extent to which they overlap with the diagnostic criteria proposed by Müller et al.

2. Case Presentation

A 61-year-old female patient was admitted to 'Prof. Dr Alexandru Obregia' Clinical Hospital of Psychiatry, in Bucharest, for depressive symptomatology. She presented willingly to the hospital, asking to be admitted for the recurrence of her depressive symptomatology in the context of some family disagreements. The patient had a history of recurrent depressive disorder, and her first episode was μin 1997. Since then, she has had a number of seven psychiatric admissions, and two of them were in the context of suicide attempts. The somatic comorbidities of our patient included arterial hypertension and type II diabetes mellitus. Her only son was suffering from schizophrenia, and the patient denied any other family psychiatric history. At the time of hospital admission, she was living with her son and her husband. She graduated from high school and completed three more years of technical training. She worked until 2004, when she retired for medical reasons (i.e. recurrent depressive disorder).

The physical examination revealed no pathological signs or symptoms except for obesity (class I). Hematological and biochemical tests were in the normal range except for leucocyte count 11.87 (reference 4.0- 11.0$^{x}10^{3}$/μL), total serum cholesterol 277.00 mg/dl (reference 0- 200 mg/dL), serum triglycerides 329.00 mg/dL (reference 0- 150 mg/dL); gamma glutamyl transpeptidase 51.7 U/L (reference 5-34 U/L), serum sodium 135.3 (reference 136-145 mmol/L). She admitted smoking tobacco cigarettes (approximately 20 cigarettes/day) and drinking moderate quantities of coffee daily. For the current psychiatric admission, the patient complained of depressive mood, irritability, tendency to social withdrawal, changes in appetite, low capacity to tolerate common daily stress and thoughts of inutility and helplessness. The patient reported that the symptoms occurred in the last month, despite her compliance with the psychiatric treatment and in the context of persistent disagreements with her husband.

The mental state examination revealed a patient oriented in person, place, and time with a sad looking appearance. She wore clean clothes, but her hair had not been dyed for some time, and she was not wearing any jewelry. Her face was sad and concerned. She was expressing a reduced range of facial expressions and few communicative gestures. Short episodes of hand wringing were noticed during the interview. After initiating visual contact at the start of the interview, her gaze became downcast and tearful soon after. The patient talked easily about the depressive symptoms, but she was reluctant when asked about her relationship with her husband and the reasons for their disagreements. She blamed herself for the family's financial difficulties and for the disagreements she had with her husband. She spontaneously expressed non-delusional inutility and helplessness ideas. She did not admit hallucinatory symptoms being present at the time of examination or in the past. She reported feeling sad most of the time during the last month and having decreased capacity to enjoy things. She denied having suicidal thoughts at the time of examination or in the last days and weeks prior to that moment. She reported a decreased quality of sleep despite what she considered to be a reasonable quantity of sleep and also reported eating more than usual without necessarily enjoying food. In the last weeks, the patient preferred to have as little contact as she could with people outside her family and did not initiate any meetings or discussions with such people, although she did not refuse others when they took the initiative.

In the following days, when the discussion about the circumstances preceding her psychiatric admission was resumed, the patient described the disagreements with her husband as being caused by "my problem", "which I have had for five years". The patient described 'the problem' as "spending all the money I have on clothes. I have bags of clothes and curtains and pillowcases and all sorts of things which I have bought. If I try to restrain myself from buying them, I just keep thinking about them; I can't even sleep at night." The patient stated that the financial difficulties and the disagreements she had with her husband are mostly caused by the fact that she spends more money than she has on things. She reported that she often had, including recently, pawned valuables (e.g. jewelry) in order to have money to buy various clothing or household items. On other occasions, she borrowed money from

her neighbors and family friends. She claimed that she had often lied to her husband in order to leave the house alone to buy more things. Only a small proportion of the items bought, especially clothes, were actually used. In fact, not all the clothes the patient bought were her size. She reported buying clothes that were a very different size just because "they were pretty" and "you'll never know". The unused items were usually stored in a separate room and eventually were offered as a gift or sold, often below the purchase price. The patient said that she feels very good both when she buys different items and when she arrives home and admires what she bought. Guilty feelings arise when she runs out of money or when her husband finds out and accuses her of not being able to stop herself. The patient described two types of buying. The first is represented by buying things that she had seen before and thought were beautiful or with possible usefulness. In this situation, the patient reported that she cannot take her mind off until she buys them and feels relieved after that. The second type is represented by momentary purchases, often of small value, things that she sees and cannot stop buying.

The patient placed the onset of CBSD five years prior to current admission, at a time period when she was separated from her husband, who was engaged in another relationship. Even though her husband came back home, her behavior persisted and seemed to represent both a reason for disagreements and a refuge when emotional and family difficulties were caused by other problems.

For depressive disorder, she was treated with venlafaxine 150 mg p.o. daily, mirtazapine 30 mg p.o. daily, quetiapine XR 400 mg p.o. daily, divalproex sodium 500 mg p.o. daily and clonazepam 2 mg p.o. daily. During her hospital admission, she continued on the same pharmacological treatment as before, as the patient refused any change because she perceived the treatment as being useful for her buying issue. The patient was visited several times by her husband while she was hospitalized. The first visits were dominated by contradictory discussions, but towards the end, they reached an agreement to offer as a gift or to sell part of the things the patient had bought in time. Later on, when she talked about her decision to sell part of the things in order to recover some of the money she had spent on them, she smilingly said that if she gets at least part of the money back, she may buy other things. The patient was discharged after 8 days, at her own request, as she had reconciled with her husband, to whom she promised to give up her habit of excessive buying.

At discharge, she received the recommendation to come back to change her pharmacological treatment taking into account that she has diabetes. Even though the patient did not categorically refuse, she postponed making an appointment. She was also recommended to start psychotherapy, but she refused, saying that the costs were too high for her to afford.

3. Discussion

Even though CBSD has been described since the beginning of the 20th century, it is not yet included in the DSM or ICD classifications. It is only presented in ICD-11 as an example of "other specified impulse control disorders" (WHO, 2019).

However, in the context of an increasing interest in the subject, Müller et al. have proposed a set of criteria for CBDS. Comparing the clinical picture of our patient to the set of criteria proposed by Müller et al., we can emphasize that the patient met all the anchor points from criteria A1 as she reported repetitive impulsive buying behavior, irresistible urge to buy, preoccupation with and repetitive, intrusive thoughts about buying and feeling relieved after buying a desired item.

She met at least five of the six anchor points of criteria A2: the patient bought more things than needed, spent more money than she intended to and could afford, had tried repeatedly to control her buying behavior and to stop thinking about buying, and she bought things under the spur of the moment. There was not enough evidence regarding the time spent in buying-shopping activities in order to establish if she met or not the description of anchor point c.

She also met criteria A3 and A4 as only a part of the items was used, she felt good when buying and the buying behavior was used to regulate emotional states.

On criteria A5, there was not enough information to establish if our patient met the description for anchor points e and g, but she clearly met the criteria for anchor points a, c, d, f as the buying disorder led to family disagreements, significant distress, negative feelings, financial difficulties and to lying to her husband about her behavior.

The patient met the description for criteria A6, B, C and D as she had negative emotional states and cognitive symptoms when she tried to resist her buying desire, the buying behavior was maintained despite negative consequences, manic episodes were excluded, and the buying behavior was not better explained by another mental disorder or medical condition.

One of the differential diagnoses taken into consideration was manic episodes, where increased buying behavior can be observed. But, in our case, the excessive buying behavior was not episodic even though the patient had repeatedly tried to reduce her buying

behavior, and the patient had no other manic symptoms or a history of manic episodes/ bipolar disorder. Hoarding disorder was excluded because the symptoms were mainly related to the buying process, and even though she gathered a large number of unused items, they were stored in a separate room without cluttering the active living areas, and the patient managed to discard them occasionally. She had also pawned valuables in order to buy items. Organic psychosyndrome was excluded based on the results of her blood tests, and the comorbid medical conditions were not consistent with symptoms of CBSD.

5. Conclusion

In this paper, our aim was to present a case of CBSD and to highlight the possible co-occurrence of depressive disorder with CBSD. Therefore, we presented the case of a 61-year-old patient with a CBSD comorbid with recurrent depressive disorder and used the criteria proposed by Astrid Müller et al. in order to establish a positive diagnosis of CBSD. Even though the proposed criteria do not state a specific number of anchor points needed to be met in order to consider criteria A1, A2, A3, A4, A5 and A6 as fulfilled, in the case presented herein, the clinical picture met almost completely the description for each of the criteria. Despite the fact that the pharmacological therapeutic intervention was not successful in our case, we consider that establishing the presence of CBSD increases the chances for a better and more successful approach in the future. Moreover, the reported case outlines that CBSD can be one of the possible comorobidities of depressive disorder; therefore, thorough psychiatric examination is necessary for accurate diagnosis and successful therapeutic intervention. Given that this is a case report, the results of future case-control or cohort studies could shed more light on this disorder.

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